Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	IL6006001		B. WING_		11/17/2015	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	and the second s	
MEADO	WS MENNONITE HOM	л 🗠	IURCH STR , IL 61726	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
\$9999	S9999 Final Observations		S9999			
THE PROPERTY OF THE PROPERTY O	Licensure Post Visi #1564135/IL79023					
	a) The facility shall procedures governi the facility. The writ shall be formulated Committee consisting administrator, the a medical advisory conformation of nursing and other policies shall complime written policies the facility and shall annually by this conformation.	esident Care Policies have written policies and ng all services provided by ten policies and procedures by a Resident Care Policy ng of at least the dvisory physician or the ommittee, and representatives r services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least mittee, documented by dated minutes of the				
	Nursing and Person d) Pursuant to subsecare shall include, a and shall be practice seven-day-a-week be 1) Medications, include properly administ 2) All treatments and administered as ordered as ordered as a large of the section 300.1620 Comprescriber's Orders a) All medications of written, facsimile or prescriber. The facsificensed prescriber is	ection (a), general nursing t a minimum, the following ed on a 24-hour, easis: uding oral, rectal, nous and intramuscular, shall tered. d procedures shall be ered by the physician. compliance with Licensed electronic order of a licensed intile or electronic order of a shall be authenticated by the	,	Attachment A Statement of Licensure Violatic	MS .	
inois Departm	ent of Public Health	vithin 10 calendar days, in  R/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	TITLE	(X6) DATE	

STATE FORM

F7SZ11

(X6) DATE

	Department of Public	c Health			FURIVI,	APPROVED
S TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:  B. WING		(X3) DATE SURVEY COMPLETED	
	IL6006001					
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MEADO	WS MENNONITE HO	₩1 <del></del>	URCH STRI	EET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROVIDERICENCY)	SHOULD BE COMPLETE	
S9999	Continued From page 1		S9999			
	accordance with Seconders shall have the unique identifier) of (Rubber stamp sign These medications ordered-by the licer designated time.  Section 300.1630 A c) Medications present be administered by the licer and the administered section 300.3240 A a) An owner, license or agent of a facility resident.  Meadows Mennonity plan of correction for These requirements by:  Based on interview failed to administer one of six residents administration in the Findings include:  The Physician's Ord November 2015 lists R2: Mild Dementia, Hypothyroidism and ists the following or Hydrochlorothiazide D 50,000 units once some (micrograms)	ection 300.1810. All such the handwritten signature (or of the licensed prescriber, natures are not acceptable.) shall be administered as insed prescriber and at the administration of Medication cribed for one resident shall it to another resident.  Buse and Neglect the administrator, employee in shall not abuse or neglect at the survey of 8/6/15, are not met as evidenced and record review the facility the correct medications to (R2) reviewed for medication is sample of six.  The same POS at medications:  12.5mg once daily, Vitamin weekly, Levothyroxine once daily, Vitamin B12	S9999			
έ	and Colace 100mg t	y, Multivitamin once daily, wice daily. None of these eduled to be administered at			Andreas and Andreas An	

Illinois Department of Public Health						
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		IL6006001	B. WING		11/1	7/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEADO	WS MENNONITE HOM	Λ <del>)</del>	URCH STRE	EET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	Continued From page 2		S9999		-	
	5:00PM.	•	And the state of t		T. C.	
	documents R2 has Status (BIMS) score to limited assistance Activities of Daily line R2's Nurses Notes documents, "(R2) with table. (R2) thought (R2) and took the difference (milligram), Toprol 22 Physician on call control to check BP (blood hour until morning  The facility's report dated 11/10/15 for R2. The sitting by another regroup and took her (sitting at the table because and took status of the sitting at the table because of the sitting at the	dated 11/10/15 at 6:40PM vas confused at the supper (R8's) medication was hers ose of Norvasc 5mg 25mg and Zocor 20mg. Intacted via phone and stated pressure) and pulse everySon contacted as well"  titled "Medication Error" cribes a medication error on the report states (R2) was esident (R8) in the dining (R2) friends pills that were by mistake. The drugs taken (Antihypertensive), Toprolesive) and Zocor 25mg				
	12:10PM, "(R8) had sitting next to (R2), of medication down took them. (E8) turn from the medication back around (R2) had medications. (E8) in supervisor and the owere no ill effects of	se (RN) stated on 11/17/15 at her medications and was (R8) must have set the cup and (R2) picked them up and hed her back to get water in cart and when (E8) turned and already taken (R8's) nimediately contacted her doctor and the family. There if the medication error."				
	On 11/12/15 at 2:00	PM E2, Director of Nursing			111111	

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ITTINOIS Department of Public Health  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUBVEY						
(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
B. WING	B. WING					
	ET					
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE			
S9999						
	•					
	A. BUILDING:  B. WING  DDRESS, CITY, S  HURCH STRE  A, IL 61726  ID  PREFIX  TAG	A. BUILDING:  B. WING  DDRESS, CITY, STATE, ZIP CODE  HURCH STREET  A, IL 61726  ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)  S9999	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING 11/1  DDRESS, CITY, STATE, ZIP CODE  HURCH STREET A, IL 61726  D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  S9999			

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